Montana Chronic Disease Prevention & Health Promotion Bureau

Community Transformation Grant Clinical Interventions

In 2009, the prevalence rates of high blood pressure and high cholesterol in Montana were 28% and 36%, respectively, with higher rates for both in the Eastern and North Central regions of the state. Over 60% of the adult population live in one of the seven most populated counties, and, according to HealthShare Montana, 60% of the primary care physicians are also located in these counties. Most primary care providers in these counties work in group practice settings in close cooperation with community hospitals. These primary care providers are the gate keepers for blood pressure and cholesterol management. Many rely heavily on the use of Physician Assistants and Nurse Practitioners to deliver healthcare to residents. The Communication Transformation Grant clinical project will establish practice-specific systems to improve the quality of care for patients with high blood pressure or high cholesterol in a primary care setting.

Project Aims	Increase the number of Montana adults with increased access to systems or opportunities that support high blood pressure and/or high cholesterol control in healthcare settings.
Project Description	Through a competitive process, the Community Transformation Grant clinical project selected practices with appropriate information technology and quality improvement infrastructure to participate in activities such as developing registries and improving office systems to improve outcomes for patients with high blood pressure and high cholesterol. Certain practices were encouraged to collect relevant Physician Quality Reporting System (PQRS) cardiovascular measures. PQRS is a voluntary reporting system providing incentive payments to eligible health professionals. Prompt periodic feedback is given to practices including local benchmarks. Practices were required to complete at least one blood pressure and one cholesterol quality improvement project. In Year 1, five Montana hospitals were selected.
Current Stakeholders (Year 1 Subaward Recipients)	**Billings Clinic** Developed a report from the dyslipidemia registry to identify patients who had no documented visit with their provider within the past year, identified patients whose last blood pressure reading were out of control, conducted outreach with patients who had hypertension or dyslipidemia and tracked patient intervention rates with 4 clinics. **Bozeman Deaconess** Identified patients with diabetes who had poor LDL and/or blood pressure control and enrolled interested patients in a lipid management clinic. Used electronic health record (EHR) to promote team based care. **Community Medical Center** Developed and piloted a blood pressure/lipid documentation tool that will be used by all primary care groups and pharmacy students to assess patient barriers to treatment. **Madison Valley Medical Center** Expanded their EHR custom reporting capabilities, established a reminder system when staff is scheduling appointments for patients with hypertension or diabetes, and added home blood pressure readings to the EHR. **St. Peter's Hospital Medical Group** Continued to facilitate quality improvement efforts for population management and outreach via a Medical Home Coordinator. A Clinical Informatics Analyst enhanced reporting capabilities in the outpatient EHR, decision support tools, and point-of-care alerts, and will produce reports for performance monitoring related to clinical quality standards.
Measuring Success	In the first year of the project, hospitals collected PQRS measures and 4 sites submitted data to the Centers for Medicare & Medicaid Services (CMS). Enhanced EHR capabilities should result in increased blood pressure and cholesterol control in patients.

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Accomplishments	All the sites enhanced their electronic health record capabilities.
Challenges	The short timeframe the first year of this project was challenging for the Cardiovascular Health Program as well as for the participating sites.
Next Steps	In Years 2-5, the clinical project will expand to additional hospitals/physicians groups, Rural Health Clinics and Community Health Centers which use ambulatory EHRs.

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